

FILED MAR 15 1940

Registration District No. 76

Primary Registration District No. 40 28

Registrar's No. 4668

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

3  
4  
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1. PLACE OF DEATH:

(a) County Caldwell  
(b) City or town Hamilton  
(c) Name of hospital or institution: 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

8. (a) PRINT FULL NAME W. P. PARSONS 125

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced wife in a

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year) 1864

8. AGE: Years 76 Months - Days - If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Indianapolis Indiana (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name unknown

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace Hamilton Mo (City, town, or county) (State or foreign country)

16. (a) Informant John Parsons (b) Address Hamilton Mo

17. (a) Highland Cemetery (b) Date thereof Feb 4 1940 (c) Place: burial or cremation Hamilton Mo

18. (a) Signature of funeral director G. P. Houghton (b) Address Hamilton Mo

19. (a) Feb 3 1940 (b) Merle Brown (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Caldwell  
(c) City or town Hamilton (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 3 year 1940 hour 3:30 minute A M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_ that I last saw him alive on \_\_\_\_\_ 19 \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death Acute Pericarditis Duration 3 weeks  
Due to 2

Due to \_\_\_\_\_  
Other conditions Myocarditis (Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (a) Means of injury \_\_\_\_\_

23. Signature L. M. Malley M.D. (M. D. or other) \_\_\_\_\_  
Address Hamilton Date signed Feb 3

7381

RECEIVED  
District Health Officer No. 11,  
District File Number 340-362  
Date Filed MAR 13 1940

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

*J.R. Haughton*

Registered Apprentice No.

working under my personal supervision.

Signed

*J.R. Haughton*

Licensed Embalmer No. 3854

P. O. Address Hamilton Me

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **6103**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **96**

Primary Registration District No. **4088**

Registrar's No. **6**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County. **Caldwell**  
(b) City or town. **Hamilton**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.  
In this community. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State. (b) County.  
(c) City or town. (If outside city or town limits write "RURAL")  
(d) Street No. (If rural, give location)  
(e) If foreign born, how long in U. S. A. years.

3. (a) PRINT FULL NAME **J. R. Parsons**

(b) If veteran, name war. (c) Social Security No.

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife. 6. (c) Age of husband, or wife, if alive. year

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years **76** Months **-** Days **-** If less than one day hr. min.

9. Birthplace. (City, town, or county) (State or foreign country)

10. Usual occupation.

11. Industry or business.

12. Name.

13. Birthplace. (City, town, or county) (State or foreign country)

14. Maiden name.

15. Birthplace. (City, town, or county) (State or foreign country)

16. (a) Informant.

(b) Address.

17. (a) (Burial, cremation, or removal) (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address.

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month **Feb** day **3** year **1940** hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death **Acute parenchymatous nephritis**

Due to **Unknown. N.M.D.**

Due to **Myocarditis**  
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **93A**  
Of autopsy.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify):

(b) Date of occurrence.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury.

23. Signature **L. M. Daley, M.D.** (M. D. or other)

Address **Hamilton Mo** Date signed

SUPPLEMENTAL

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 6103  
Registrar's No. 6

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 96

Primary Registration District No. 4058

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County Caldwell  
(b) City or town Hamilton  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED: mo  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME John R. Parson

20. DATE OF DEATH Month Feb day 3  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color of hair w 6. (a) Single, widowed, married, divorced w

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
76 - - in \_\_\_\_\_ min.

Immediate cause of death \_\_\_\_\_

9. Birthplace (City, town, or county) (State or foreign country)

Due to \_\_\_\_\_

10. Usual occupation \_\_\_\_\_

Due to \_\_\_\_\_

11. Industry or business \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

12. Name \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

13. Birthplace (City, town, or county) (State or foreign country)

Of autopsy \_\_\_\_\_

14. Maiden name \_\_\_\_\_

15. Birthplace (City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_ Underline the cause to which death should be charged statistically.

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) April 20 1940 (b) Merle Brown (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature L. M. Daley (M. D. or other)

Address Hamilton mo Date signed \_\_\_\_\_

SUPPLEMENTAL